Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Stakeholder Input Process

General Stakeholders Meetings
April 5, 2005 – Burbank
April 6, 2005 – Sacramento

Meeting Summary
For Discussion Only

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I. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Act has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the MHSA are designed to support one another in leading to a transformed culturally competent mental health system. This is reflected in the California Department of Mental Health's *Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act* of February 16, 2005: "As a designated partner in this critical and historic undertaking, the California Department of Mental Health will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA, DMH pledges to look beyond "business as usual" to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists."

The general stakeholder meetings on April 5 and 6, 2005 were the second series of general stakeholder meetings and the first general stakeholder meetings held since the December 17, 2004 meeting. The April 5 meeting in Los Angeles and the April 6 meeting in Sacramento used the same agenda and have one combined summary of both meetings.

A client and family member (CFM) pre-meeting, held from 9:30 – 11:30 a.m. on both days, provided an opportunity for clients and family members to discuss the afternoon general stakeholder meeting purpose, review the agenda, ask questions, provide feedback and network with each other. Both the pre-meeting and the general stakeholder meeting were introduced with the same general overview. The general stakeholder meeting was held from 1:00 – 4:00 p.m. on both days.

One hundred five (105) people attended the morning CFM pre-meeting in Los Angeles and 64 attended in Sacramento for a total of 169 clients and family members. One hundred forty nine (149) people attended the afternoon stakeholder meeting in Los Angeles and 155 attended in Sacramento for a total of 304 stakeholders.

Since the December 17, 2004 meeting, the MHSA stakeholder process has conducted six workgroups:

- Workgroup on Cultural Competence — February 23, 2005
- Workgroup on CSS DRAFT Plan Requirements Sections I-IV — March 7, 2005
- Workgroup on Small County Issues — March 16, 2005
- Workgroup on Short-Term Strategies — March 16, 2005
- Workgroup on CSS DRAFT Plan Requirements Sections V-IX — March 23, 2005
- Workgroup on CSS Financing — March 30, 2005

DMH staff has received over 700 emails, hundreds of telephone calls to the MHSA toll-free number, and many letters and position papers. In recent weeks, there has been substantial activity in the process of appointing the MHSA Oversight and Accountability Commission, with the intention of the Administration to hold the Commission's first meeting in early May. Finally, $60 million have been deposited in the Mental Health Services Fund (MHSF) account from Proposition 63 tax revenues.

This summary reflects the content, questions and comments from both the April 5 meeting in Los Angeles and the April 6 meeting in Sacramento.

A. Meeting Purpose

The outcomes of the general stakeholder meeting were to:

1. Bring stakeholders up to date on progress with MHSA Implementation since the December 17, 2004 general stakeholder meeting

2. Review major themes of feedback on CSS DRAFT Plan Requirements and identify DMH preliminary approaches to changes

3. Identify progress on implementation of short-term strategies based on stakeholder feedback

4. Learn how different counties are implementing local planning processes and share ideas for involvement of a broad range of stakeholders

B. Schedule of Meetings

- A new series of workgroup sessions is currently scheduled on May 4 and May 16, focused on performance measures. Additional meeting and conference call dates and times will be posted on the MHSA website on Friday, April 8.
- The next general stakeholder meetings will be held on July 7 in Los Angeles and July 8 in Sacramento.

II. Client and Family Member Pre-Meeting (9:30 – 11:30 am)

One hundred five (105) people attended the morning CFM pre-meeting in Los Angeles and 64 people attended the CFM pre-meeting in Sacramento, for a total of 169 clients and family members. This is the combined summary of both meetings.

A. Welcome and Introductions

Bobbie Wunsch, Pacific Health Consulting Group (PHCG) and facilitator of the MHSA stakeholder process, introduced the client and family member session. Spanish and American Sign Language (ASL) interpreters were introduced and available to ensure that everyone was able to participate fully in the meeting. In Los Angeles, Korean interpreters were available provided by one of the groups in attendance. Ms. Wunsch encouraged people to pre-register for meetings, so that the need for interpretation services could be identified and met and the meeting room could accommodate the needs of all participants. Ms. Wunsch reviewed the agenda for the afternoon general stakeholder meeting.

Client and Family Member Questions and Comments

Communication with DMH

- How can we contact DMH to provide feedback?
  - Toll free number: 1-800-972-MHSA (6472).
  - Email: MHSA@dmh.ca.gov
  - Website: www.dmh.ca.gov. DMH posts everything on the website.

- How can people know if their input has already been provided during the process?
  - **Pacific Health Consulting Group (PHCG) Response:** During the meeting this afternoon, the DMH will review what they have heard. If you do not hear your concerns raised, send in your comments. During lunch, talk to DMH staff.
  - **CFM Response:** The summaries of the meetings posted on the website show what issues and concerns have already been raised.

- The California Network has a position paper on the CSS DRAFT Plan Requirements. When would be the best time to distribute it?
  - **PHCG Response:** Please distribute it now.

- A pink sheet about “Nothing About Me Without Me” is also being distributed. This is the slogan of the disability community and is part of the United Nations Convention on Human Rights and of the Client Network.

Stakeholder Process

- We all have something to say, but we want to know it is being recorded and noted.
  - **PHCG Response:** Two recorders are listening carefully to what is being said and will turn this into a combined summary of both general stakeholder meetings. After these summaries are completed, DMH reviews them. The summaries will be posted on the DMH website by April 19.
  - **DMH Response (Carol Hood (CH)):** DMH staff has reviewed all the summaries from the workgroups carefully. DMH has received over 700 emails as well as letters from constituency groups and individuals. The MHSA toll-free line has received hundreds of calls. All of this input has been summarized and DMH has begun internal discussions on policy and practical issues with Dr. Mayberg, DMH Director. From these discussions, a team of DMH consultants and staff will re-

write the CSS Plan Requirements. This afternoon, DMH will share what it has heard. If the presentation shows that DMH missed a point, stakeholders should say so. DMH staff will describe its preliminary approaches to the changes. DMH will continue to accept input into the CSS DRAFT Plan Requirements until April 11.

- What is the purpose of the workgroup meetings: to set policy or to provide guidance?
  - **PHCG Response:** Today's meeting is a general stakeholders meeting to give everyone involved in the MHSA an update on what has happened since December 17, 2004. General stakeholder meetings are quarterly updates. The purpose of the workgroups is to address specific technical topics and for stakeholders to provide feedback. These meetings are on specific technical topics. Input is advisory and the meetings are not intended to reach consensus. The next workgroups, on May 4 and 16, 2005, will be focused on performance measures. If you have special knowledge, special interest or special experience you would like to share about performance measures, these are the meetings to attend. If you are unable to attend, you can follow the process by reviewing the summary, which will be posted on the website.
  - **DMH Response (Marilynn Bonin (MB)):** The stakeholder process including workgroups and stakeholder meetings is not set in stone. Tell DMH what you think. Do you want to talk about IT, human resources and facilities in the same way CSS was discussed? Planning for the planning process is still underway.

- Why are the counties not participating in the stakeholder process?
  - **DMH Response (MB):** The counties are encouraged to come to these meetings. The California Mental Health Directors Association (CMHDA) is also holding ongoing meetings. More county staff comes to the afternoon meetings.
  - **PHCG Response:** Counties will also get a letter telling them what they need to do after the final CSS Plan Requirements are released.

- There appear to be subtexts about the need to produce results, due to the political pressures. We are waiting for the Governor to make appointments and there are so many issues that relate to the MHSA Oversight and Accountability Commission. This is probably a hotly discussed issue within the Department. Can DMH staff share some of these issues as they are discussed? Does the Department know what it wants to measure? If DMH can share this with stakeholders, it will allow for more useful feedback.
  - **DMH Response (Dee Lemonds (DL)):** DMH is concerned that MHSA needs to show results quickly. Staff feels some pressure to show the California taxpayers that they were right to pass this. At the same time, there is already an effort to overturn it. DMH staff are paying attention to the pressures, but are not allowing them to drive the decisions. Just conducting the public planning process on the local level and the visibility across the state are considered immediate results.

- Can DMH keep stakeholders abreast of it? While it is hard to discuss in public, it helps stakeholders to be responsible together with DMH.
  - **DMH Response (MB):** The short-term strategy effort is intended to demonstrate immediate results in outreach and education.

CSS Plan Requirements

- Has there been a revision of the CSS DRAFT Plan Requirements?
  - **PHCG Response:** No. There have been three workgroup meetings and conference calls on the CSS DRAFT Plan Requirements. Hundreds of people have made suggestions about changes. The final deadline for feedback is April 11. DMH is considering what changes will be made. On May 15, 2005, DMH will release revised requirements.

- Please provide clarity on the April 11 deadline.
  - **PHCG Response:** You can give feedback on the CSS DRAFT Plan Requirements by phone, email, or mail through the end of the day April 11, 2005.

- We heard a couple of weeks ago that the final CSS Plan Requirements would be released on May 1. It looks like there is a delay. People are waiting to hear about their county allocations.
  - **DMH Response (MB):** The reason for the delay is to allow the MHSA Oversight and Accountability Commission to weigh in on the requirements at its first meeting that is planned for May. It is unlikely that DMH will release the allocation amounts separately from the CSS Plan Requirements.

- Has the decision been made about the plan due date?
  - **DMH Response (CH):** DMH will not have one due date for all counties. Counties will submit their plans as they are ready. DMH will batch the plans and process them through the approval process. Counties cannot be reimbursed for services until their plan has been approved. It is transformative for DMH not to require a deadline for the plans.

- Is there a mandate on performance before a percentage of money is released?
  - **DMH Response (DL):** DMH hopes to look at performance in multiple ways, over the course of time. Right now, performance will not be considered as part of the allocation. In May, DMH and stakeholders will begin discussion about performance measures.

- The CSS DRAFT Plan Requirements are not final yet, however, counties have had to submit their plan-to-plan and are now in the process of planning. There is a lot of pressure from agencies that have cut programs because of funding cuts. These Requirements should have been issued yesterday, and they are important to release now. There has been a lot of wasted time put in by counties.
  - **DMH Response (CH):** This is the biggest challenge of MHSA: communities are moving forward, and people want to see the benefits of MHSA. There is an ongoing tension between the desire to move quickly to get the money out to the

counties and the need to be deliberative enough to develop a sound program. DMH did not have a grand strategy for implementation and this process challenges the Department's flexibility. It forces DMH to determine outcomes, how they will be measured, how to implement the other MHSA components of human resources, IT, and prevention. In addition, DMH needs more staff, much as the counties do.

Oversight and Accountability Commission

- Who is on the Commission?
  - **DMH Response (MB):** The composition of the MHSA Oversight and Accountability Commission is written into the law. There are sixteen members, representatives from the Attorney General, the California State Senate and Assembly, the Superintendent of Public Instruction and twelve appointed by the Governor. The appointment applications have all been received and decisions are being made. There will be a press release when the decision on all appointments is complete.

- How are the client and family representatives selected?
  - **DMH Response (MB):** Department staff has not heard from the Governor's Office. The legislation states that the Governor should seek Commission members, no matter what their position, who have personal or family experience with mental illness. MHSA also states that there can also be an advisory group of clients and family members.

- The Oversight and Accountability Commission needs to approve plans, but the Commission has not been appointed yet. How will this delay plan approval?
  - **DMH Response (CH):** The Commission will have some review responsibilities; however, authority for approval lies with DMH. Since the first meeting of the Commission is expected in May, there should be no delay for counties.

Supplantation and Maintenance of Effort

- Will the definition of supplantation be part of the release of final CSS Plan Requirements?
  - **DMH Response (CH):** In the initial drafting of MHSA, advocates wanted to make sure that the existing state funding for mental health was not taken away in anticipation of MHSA. To achieve transformation, counties need to build on what is already in place. MHSA contains a paragraph about what cannot be done with state MHSA money. There is one statement about a prohibition on counties to supplant, which says that current funds cannot be used for something other than mental health. There is little guidance about supplantation and maintenance of effort (MOE). People at the local level are waiting for direction. The DMH position is that supplantation and MOE is a legal discussion to be left to DMH attorneys. When CSS final plan requirements are issued, they will include explanations of supplantation and MOE.

- In Southern California, counties are considering funding programs that were de-funded a couple of years ago. Clients and family members believe this is neither transformation nor spirit of law, and therefore supplantation. These are not new programs, even if they are evidence-based practices.
  - **DMH Response (CH):** The DMH position is that MOE for the State is the aggregate amount of money spent on mental health services, not on particular programs. The effective date for establishing the supplantation amount for the State (or DMH) is 2003-2004. For counties, the whole issue is less clear. The drafters appear to be much more concerned about the State than the counties, but DMH is looking to define MOE for both.

- Our county lost funding for mental health courts. Law enforcement and criminal justice want to restart the courts. Will this be permitted with MHSA funding? How are other counties doing this? These types of issues are real concerns for clients and family members.
  - **DMH Response (CH):** MHSA has no prohibition about doing what has been done before. It talks about expansion, as long as it is in the spirit of MHSA. The criterion is not whether it was done before, but whether it is consistent with MHSA.

- Why was Fiscal Year (FY) 2003-04 chosen for the baseline and why was aggregate funding chosen rather than program funding? Our county budget was increased this fiscal year but services were cut.
  - **DMH Response (CH):** FY 2003-04 for State MOE comes directly out of the statute. It is likely that the drafters of the legislation were concerned that because the State budget was in such a crisis, the Governor and legislature might cut mental health services funding in anticipation of MHSA. The specific base year for counties' MOE is still under discussion.

- If funding must be kept at the FY 2003-04 level, what kind of precautions will be in place if it is not? What is DMH doing to ensure the MOE on the state level?
  - **DMH Response (CH):** The Administration's position is that MOE is aggregate funding on the state level. This means that while the Children's System of Care (CSOC) funding may have been cut, other children's services, such as EPSDT, had large increases, so the aggregate is intact.

- CSOC and EPSDT are different programs.
  - **DMH Response (CH):** DMH is using the aggregate calculation.

- Clients and family members understood the MOE on the program level.
  - **DMH Response (CH):** There is a difference of opinion.

Involuntary Treatment

- MHSA is about the promise of transformation within the implementation. The Client Network is concerned about involuntary treatment and funding services that are in the spirit of the MHSA.

- MHSA is supposed to promote new services. The proposal for involuntary treatment is not a new concept. The California Network opposes MHSA funding for involuntary treatment.
    - **PHCG Response:** There have been many comments about involuntary treatment at every meeting.

B. Small Group Discussions about County Stakeholders Involvement

Clients and family members were asked to sit at tables with people they did not know from counties other than their own to discuss the positive aspects of their counties' stakeholder processes and the areas that need improvement. The clients and family members were asked to respond to the following two questions:

- *What are counties doing to positively involve client and family member stakeholders in the planning process?*

- *How can counties improve involvement of client and family member stakeholders in the planning process?*

Please note: Participants did not always identify which county they were referring to in their comments.

1. Southern California Counties

The counties of Los Angeles, Orange, Riverside, San Bernardino, San Francisco, Santa Barbara, Santa Cruz, Tulare and Ventura were represented in the small group discussions in Southern California.

What are counties doing to positively involve client and family member stakeholders in the planning process?

Inclusion of Clients and Family Members

- Los Angeles County's stakeholder process began last year.
- Los Angeles County has a very active mental health director who is very committed to the process and encourages involvement from many constituencies. Clients are very involved. The administrators are very supportive of having clients involved in the planning process. Clients and family members meet with the director monthly on an equal footing.
- In Los Angeles County, families and parents are being invited to participate in focus groups and trained to participate fully. They have formed mothers and daughters groups.
- Orange County's Steering Committee is up and running. Meetings are held at a variety of times, places and languages convenient for clients and family members.
- In San Bernardino County, things are going pretty well.

- San Bernardino County, which is geographically challenged, has been using video conferencing to reach the corners of the county.
- In Santa Barbara County, County Mental Health is trying to find ways to bring more people into the discussion, not just the usual groups.
- In Santa Cruz County, after an outspoken advocate came twice to the Mental Health Board to object to the process as begun, the process is improving.
- Tulare County has a comprehensive plan that started last September, with a 30-member implementation committee. It has held two public forums so far with more scheduled. In the beginning of the process, there was a lot of complaining, but now the process is moving in good directions.
- Staff caseworkers are supporting consumers.
- One county's director is providing interpretation in the stakeholder process, which increases participation among Latinos. Latinos are not well educated about this process.
- The various related boards and commissions are involving clients and family members.

Hiring of Clients and Family Members

- Orange County is training clients and family members to conduct outreach and obtain feedback.
- Los Angeles County is hiring people from the peer advocacy training to conduct focus groups.
- In Los Angeles County, clients are screening applicants for hiring in the process.

Outreach

- Los Angeles County is using the providers in its wraparound programs to gather more information from people.
- Los Angeles County is reaching out to the Asian Pacific residential community.
- Orange County has residents speaking many different languages. Their MHSA process includes meetings with Spanish and Vietnamese interpreters, attended by at least 100 people. They are conducting a tremendous amount of outreach.
- San Bernardino County is reaching out to faith-based organizations.
- Word-of-mouth is important in reaching out to and involving people.

Collaboration

- Los Angeles County has many parts of the process in place with a lot of involvement from the California Network.
- In Orange County, NAMI is very involved.
- In San Bernardino County, disparate groups are working together.

Programs That Are Successful

- The Team House Program in San Bernardino County is a very important program that encourages clients to go out of their houses and be productive. The Team House clubhouse is not just a place to relax. It offers many positive opportunities:

people go to school and get vocational training for employment. Programs like this should be expanded with MHSA funds.
- In San Bernardino County, NAMI has conducted eight-week mental health workshops at Team House. Families come in to talk about mental health issues and learn about the clubhouse.
- San Bernardino Team House takes care of people no matter what their problems. It is for both people with mental illness and for people who are homeless.
- NAMI and Pacific Clinics work together at the Santa Fe Social Club.
- Los Angeles County offers a six-week college course for clients to learn about mental health conditions.
- In Ventura County, law enforcement is working better with the Crisis Intervention Team.
- Our Place provides socialization, learning and education. Here people find friends and increase their knowledge. Clients need to feel better when done with treatment, not worse about themselves. They need activities and problem-solving skills, rather than being treated criminally.
- One county offers consumer training opportunities for employment, including peer-to-peer programs. Many of these trainees are hired by community-based organizations. These staff help other consumers get to appointments and access services. Many people who start as trainees become trainers.

How can counties improve involvement of client and family member stakeholders in the planning process?

More Inclusion of Clients and Family Members
- Board meetings and committee meetings for MHSA in Ventura County are announced as closed, but they are indeed open and should be presented that way. Clients and family members need to participate in stakeholder meetings.
- NAMI in Los Angeles County has been trying to find its way and is concerned it has been left out of the loop. Something has happened in communications. Work with NAMI to support families and consumers.
- This stakeholder process was not designed by clients who would have done it differently.
- Train clients and family members in community outreach to sit on stakeholder committees.
- Higher functioning clients are participating, but not clients with less functioning. Need to make sure that they are participating in the system.

Meeting Accessibility
- A couple of structural issues are challenging for counties: language and geography. In Southern California, often as many as 200 different languages are represented.
- Client and family member counselors are participants. They need more support, including interpreters and more outreach.
- This meeting needs childcare services.

- Need to overcome the language barrier to include more monolingual non-English speakers.

More Outreach
- Need more outreach and services to everyone.
- Conduct outreach in rural areas.
- Need more outreach to the underserved communities. Latinos are left out, but deserve to be heard in this process.

Training
- In San Bernardino County, consumer employment and training needs to be included. CSOC cannot be diminished.
- Provide training to parents who do not know how to work with schools or navigate the Individualized Education Plan (IEP) process to obtain appropriate services for their children. This can prevent the children from becoming adults in the mental health system.

Leadership and Staffing
- San Bernardino County does not have a mental health director at present, creating a leadership void.
- Leadership must believe in what they are doing. They must get a greater understanding of what is needed by clients and family members. They need to visit facilities to see for themselves and not just do what they are told.
- Need full-time staff to get things up and running.

Timing
- All counties are struggling with the time problem: in some places, the process moves too fast; in others, too slow.
- Clients and family members find the employment process under MHSA too slow.

Other Improvements Needed
- Need more therapists and caseworkers.
- Some family members do not have education about how to access services.
- Many people are still not accessing services.
- Do more with the press to reduce stigma.

2. Northern California Counties

Sharon Kuehn and Joan Beesley, Client and Family Member Advocates, facilitated this portion of the meeting in Sacramento on April 6, 2005.

The counties of Alameda, Amador, Contra Costa, Fresno, Mendocino, Monterey, Sacramento, San Francisco, San Joaquin, Santa Clara, Shasta, Solano, Sonoma,

Stanislaus, Trinity, Tuolumne, Yolo were represented during the client and family member meeting.

What are counties doing to positively involve client and family member stakeholders in the planning process?

Inclusive Process

- Advent of MHSA itself provides an opportunity for people to speak their minds to promote change.
- MHSA stakeholder process lends itself to people coming together from different parts of the State to transform the mental health system.
- UACC trainings on MHSA provide a fast track that helps to kick-start the process.
- MHSA provides an ability to participate, a sense of hope and the chance to speak to DMH.
- Focus groups are conducted during regular meetings and in locations familiar to clients.
- There are multiple layers of opportunities to participate: brown bag lunches, engagement groups, focus groups, and stakeholder groups.
- There is an active public process, involving client and family members that includes media coverage and newspaper articles.

Client and Family Member Participation

- Sacramento County has a very good organizational chart. Each committee is co-chaired by county staff and a member of Mental Health Board.
- Santa Clara County's mental health director is determined to obtain feedback from 15,000 clients from among the 25,000 total in the county.
- Contra Costa County has a structure for client empowerment and involvement that many counties could benefit from learning more about.
- Shasta County has a very responsive director and Mental Health Board.
- Yolo County has adequate client and family member representatives in the planning process.
- Sonoma County is very organized and has planning committees with clients and family members as equal participants.
- Several counties have consumer co-chairs for the planning committees.
- 50% participation by clients and family members on all committees.

Hiring Clients and Family Members

- San Joaquin County is hiring clients and family members for the planning process.
- One county director wants clients and family members to assist in writing the plan.
- Full-time client, family member and youth advocates.
- Clients and family members run focus groups.

Collaboration

- Sacramento County's Mental Health Board is an essential part of the process and collaborates effectively with consumers.

- Working with existing collaboratives.
- Outreach is conducted collaboratively with the county, grassroots organizations and individuals.
- The MHSA has fostered communication with groups that have not always been on the same page.

Training to Participate

- Training for clients and family members to facilitate the focus groups, participate in the planning and assist in outreach.
- Conducting pre-leadership meetings, which provide clients and family members with training to participate fully.

How can counties improve involvement of client and family member stakeholders in the planning process?

Improvements in Decision-Making

- Alameda County client and family member representatives have been handpicked by the county, not by the client and family member groups.
- In Contra Costa County, the value of consumer input is ambiguous.
- In Sacramento County, advocates are hearing from the county that they have already pre-determined the planning process. They are not looking at MHSA to increase access, but to give access to those who have already been identified as underserved and those who are unserved. While it is true these groups are underserved or unserved, this still leaves many people out of the decision-making process.
- State and county staff who serve as advocates need to educate each other on ethics. They need to be accountable to their clients and their jobs. Ethics of advocacy for our peer advocates must be addressed at the state level that includes compassion, listening and understanding, without fear of intimidation or reprisal.
- Concern about where final decision is made. Will clients and family members be included in the final decisions?
- Clients and family members are concerned that the counties and the central decision-makers are isolated. We need to figure out how to get them to hear us.
- Seeing nervousness of staff, possibly related to sharing power with clients and family members.
- The structure is not set up to listen to consumers and there is no leverage to get change made.
- There are lots of fears among consumers that the county has already decided the plan. County people are not returning calls from consumers.
- Need to have client and family member input heard and operationalized.

More Inclusion of Clients and Family Members

- Amador County has not held planning meetings. Only $1,000 of the $81,000 planning grant will be spent on stakeholders. $80,000 is being spent on a professional consultant. Need to include more stakeholders in the planning process.

- MHSA process lacks recognition of tribal groups as sovereign nations and omits tribal groups from MHSA planning process. Mendocino County has done nothing to address this. There is nothing in the county's preliminary plan to reach out to tribal groups.
- In San Francisco, there is concern that voices are not being heard. The process lends itself to exclusion of consumer groups.
- Solano County has 45 members on their Steering Committee; only three are client and family members, while five are union representatives.
- Hold meetings where the clients and family members are. Have meetings at accessible places and varied times.
- A lot of county-run stakeholder meetings are closed. They should all be open.
- Clients fear that consumers' perspective will be lost among the other interest groups.

Meeting Accessibility

- There is a disincentive for clients and family members to participate and a built-in barrier because money is not provided up-front to cover expenses, but reimbursed after the meetings.
- Develop a special fund to reimburse clients and family members through the California Network and NAMI, to advance people their expenses, rather than as a reimbursement later.
- Clients and family members are required to attend meetings in distant places, rather than bringing the meetings to them.
- Provide childcare for parents, not the money for childcare.
- The cost of attending state and local meetings is high. Some people are funded by their counties to attend meetings across the State. Many are not.
- Help people get to the MHSA planning meetings.

More Outreach

- San Francisco needs to reach out to refugees.
- Use more conference calls to increase the outreach.
- Information needs to be available on the web.
- Need more cultural and ethnic outreach. A lot of groups still need to be reached out to. Groups are missing, including native people, refugees and transition-age youth.
- Need more feedback and education about how to get the information out.
- Clients and family members do not know how to get information or have a clear way to become involved. There is a lack of publicity that informs people how to get involved. Need to use newspapers, radio and public access TV.
- Training needs to be more inclusive and model more expansive outreach.

Other Improvements Needed

- Need more training for peer support.
- Building trust in a system that has been based on force is difficult. More efforts must be made to level the playing field so that clients can better participate.
- Smaller counties have relatively less money to organize.
- Need centralized training to prepare local staff.

III. General Stakeholder Meeting (1:00 – 4:00 p.m.)

One hundred forty-nine (149) people participated in the general stakeholders meeting in Los Angeles on April 5, 2005 and 155 attended in Sacramento on April 6, 2005 for a total of 304 stakeholders.

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, introduced American Sign Language (ASL) and Spanish interpreters.

A. Welcome, Introduction and Purpose of the General Stakeholders Meeting

Ms. Wunsch welcomed everyone to the first general stakeholders meeting since December 17, 2004. About one-third of the participants in Los Angeles and well over half of the participants in Sacramento indicated that they had attended the December 17 meeting.

The following counties were represented at the general stakeholder meetings on April 5 and 6, 2005: Alameda, Amador, Colusa, Contra Costa, Fresno, Lake, Los Angeles, Marin, Mendocino, Merced, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Solano, Sonoma, Stanislaus, Trinity, Tuolumne, Tulare, Ventura, Yolo and Yuba.

Ms. Wunsch reminded the stakeholders that every person present had something important to contribute. She urged people to limit their comments in the interests of allowing everyone the opportunity to speak.

Ms. Carol Hood, DMH Deputy Director, introduced a training film about the MHSA produced by the California Institute for Mental Health (CIMH). The opening of the film describes why the MHSA is so important and why DMH and the stakeholders are working hard to implement it well. These first few minutes illustrate the vision, the emphasis on empowerment and recovery and the opportunity to build a system that is responsive to the needs of clients and families. The film is being provided to each county to use in its planning process. For additional copies, contact James Hernandez at CIMH at 916-566-3480, ext. 100.

Stakeholder Questions and Comments

- Is DMH email only in English or in other languages such as Spanish? What about the MHSA toll-free line?
  - **DMH Response (CH):** The MHSA toll-free telephone is in English and Spanish. When people leave a message in Spanish, staff can respond in the caller's

language. Email messages sent in other languages will be translated and responded to.

- Is there something on the website that lets non-English speaking people know they can do this?
  - **DMH Response (CH):** We will check into our process and revise it if possible to meet that need.

- Will the CIMH training video be available in other languages?
  - **DMH Response (CH):** Rachel Guerrero from the DMH staff is working with the producer about translating the film into Spanish and Vietnamese.

B. Progress on MHSA Implementation since December 17, 2004 General Stakeholder Meeting

Marilynn Bonin, DMH staff, provided a brief overview of the first 95 days of MHSA, including the numbers of people involved, meetings held, and contact information. DMH staff has received over 700 emails, hundreds of telephone calls to the MHSA toll free number, and many letters and position papers. In recent weeks, there has been substantial activity in the process of appointing the MHSA Oversight and Accountability Commission, with the intention of the Administration to hold the Commission's first meeting in early May. Since the general stakeholders meeting on December 17, 2004, which was attended by about 550 stakeholders, there have been six workgroups to work on MHSA technical issues, each preceded by a statewide conference call.

Stakeholder Questions and Comments

- Include deaf culture as an underserved group.
  - **DMH Response (Carol Hood (CH)):** Focus on cultural competence at the cultural competence workgroup was on culture, rather than on the physically disabled. Since then, DMH has held a number of meetings with a number of groups representing the disabled community.

- Sight access to public transportation is an important issue for blind clients. They are forced to rely on paratransit, although it is not necessary for most sight-impaired clients.

- The lack of culturally competent services for deaf mentally ill clients requires them to bring interpreters, which breaks confidentiality.

- Systems of Care has already proven to be effective.
  - **DMH Response (Marilynn Bonin (MB)):** System of Care is included in the MHSA.

- **DMH Response (CH):** Building for transformation requires a long-term perspective. DMH is taking steps that build toward a changed system. For example, DMH wants to change Medi-Cal requirements. It cannot be done immediately, but the Department will work toward it systematically. DMH is trying to build for the future and create a more flexible system.

- Is MHSA for people with Medi-Cal?
  - **DMH Response (CH):** Priorities for the MHSA are those who are unserved and underserved. Most do not have Medi-Cal but some do. DMH has selected some populations with Medi-Cal, such as youth graduating out of the foster care system. Some of these youth may still have Medi-Cal.

- Why are you talking about Medi-Cal, when the MHSA is for the uninsured and unserved?
  - **DMH Response (CH):** In the current mental health system, about $1.5 billion comes from Medi-Cal, about a third of the total budget. Some Medi-Cal beneficiaries will be eligible for MHSA services. Medi-Cal beneficiaries are often underserved because important services are not always covered. Many people wish Medi-Cal would change some of its rules to change this situation, but such change is a very slow process.

- What are the requirements for Medi-Cal? A great number of homeless people do not meet the requirements for Medi-Cal and yet they have many medical and mental health problems.
  - **DMH Response (CH):** Many would agree. People with great needs often do not qualify. The person must be deemed eligible, the provider must be certified, and the service must be a covered benefit.

C. Themes from Stakeholder Feedback and Next Steps on Community Services and Supports DRAFT Plan Requirements

Mike Oprendek, DMH staff, presented a summary of what DMH has heard from the feedback. The complete PowerPoint presentation, *MHSA CSS Planning Process Feedback: What We Heard You Say…,* can be found on the DMH website. On every issue, the Department has heard a wide range of comments with a wide variety of opinions.

<u>Themes Heard from Stakeholders</u>

Embedding Cultural Competence

- Include ethnicity and gender in more of the required data.
- There needs to be de-stigmatization for all populations.
- Evidence Based Practices do not include cultural competence issues; more research is needed.
- Increase emphasis on reduction of ethnic disparities in public mental health services.

- Include native tribes in county planning.
- Culture and lifestyle must be included in all discussions.
- Collaborate with community leaders, churches, faith-based organizations and community health clinics and other primary care providers.
- To improve staffing, provide higher pay for bilingual or multi-lingual staff who must be certified.

Children, Youth and Their Families

- CSOC and wraparound are MHSA basic concepts and need more emphasis.
- Homelessness should be included as focal population.
- The values and goals described in the CSOC framework are not adequately emphasized.
- Current language reads as an "adult" document rather than reflecting the language of children, older adult or transition age youth.
- Current resilience definition needs to be changed to be more supportive of the positive role of parents.
- SOC should be a model for enrolled families.
- "Recovery" is adult language; "Full inclusion" is more pertinent for children who do not recover in the same way.

Increased Focus on Peer Support and Family Education Services

- Provide models or templates for self-help groups.
- It seems like peer programs are in the margins, not in the center.
- Do not forget current problems and current clients as we create new systems.
- Transportation is a huge issue.
- Clients in self-help groups do not want to report to the county; they may not trust the county.
- Provide peer support for those with dual disabilities.

Enrollment

- Need to change the language to "membership" or "participant."
- Maintain balance of focus on services and "slots" for enrolled members and increasing variety and amount of MHSA services for others in need.
- Change requirements to allow strategies selected by local planning process.
- Need to maintain the requirement to be consistent with the MHSA.
- "No substitute for enrollment for evaluation purposes."
- The concept of "whatever it takes" has more to do with the underlying concept rather than enrollment.

Small Counties

- Agree with need for flexibility in requirements for small counties, recognizing resource restrictions.
- Small counties need more money and staff because of geographic distances and small pockets of population.
- Encourage cross-county and cross-agency collaboration.

- Provide assistance to help use our funds locally to help with housing. Counties need flexibility for setting people up in apartments.

Involuntary Treatment

- Eliminate the option to fund an expansion of involuntary treatment. Other funds can be used for that. This is contrary to the intent of the MHSA. Comments included:
  - Some involuntary care is essential.
  - The MHSA was to focus on expansion of voluntary care.
- The goal to reduce involuntary services should be retained.
- Requirements should balance the needs of the caregivers with the alternatives offered to the person diagnosed with SED or SMI in a time of crisis.

Outcomes and Performance Measures

- Need to add focus on individual needs and outcomes.
- Ensure that there are outcomes from the beginning—critical for accountability.
- Reduce the requirements for documenting outcomes—the new paperwork will take away from service provision.
- Integrate outcomes more throughout the document.
- Use independent audits versus specific measures for outcomes.
- Focus on outcomes rather than programs:
  - Safe living environment
  - Supportive relationships
  - Meaningful way to use one's time

Short-Term Strategies

- Expand training.
- Need training for transformation: tools and technical assistance.
- Statewide coordination.
- Focus on education to family and clients is fundamental.
- Support for telemedicine and Network of Care.
- Utilize the statewide suicide prevention plan and fund the start-up.

Distribution of Funding

- Provide more clarity about proportion for planning estimates and set-aside.
- Ensure county prudent reserves, these eliminate the need for a state set-aside.
- Basic factors in planning estimate seem reasonable.
- Difficult to know impact of those factors when relative weighting and source of data are unknown.

Funding limitations

- Maintain requirement that funding should not be allowed prior to approval of plan to ensure transformation for all populations served.
- Allow use of funds prior to approval of plan so expanded services can begin quicker.
- Stakeholder process should be used for non-supplant/maintenance of effort requirements.

- Since the non-supplant/maintenance of effort requirements are technical legal interpretations,Sstate should issue policy as final.

Overall Requirements
- Need to streamline overall requirements; current draft plan requirements are overwhelming.
- Reduce requirements for planning description.
- Budget formats are too complex and inconsistent with current systems.
- Submit workforce analysis separately.
- Provide examples.

Then Ms. Hood provided an overview of the DMH preliminary approaches to changes to the CSS DRAFT Plan Requirements. In addition to the PowerPoint presentation, she noted that at this time, DMH does not plan to make changes to the requirements concerning involuntary treatment and acknowledged that this is a disappointment to those who have provided such thoughtful feedback. She also noted that no changes had been made to the financing sections. Finally, she acknowledged the value of all the feedback, which will improve the quality of the document in its final version.

Preliminary Proposed Changes to CSS DRAFT Plan Requirements

Embedded Cultural Competence
- Revise staffing forms to require more data on ethnicity and gender.
- Require periodic reporting on improvements in access for ethnic populations.
- Clarify that outreach in stakeholder process needs to include Native Americans.

Children, Youth and Their Families
- Change language in requirements to make more consistent with children/youth services.
- Reaffirm Department's commitment to Children's System of Care principles and outcomes.
- Emphasize MHSA requirements for child/youth services, including wraparound.

Increased Focus on Peer Support and Family Education Services
- Require expansion of peer support and family education services to be a component of the CSS three-year plan.
- As part of the Education and Training component, propose that one of the initial priorities be focus on increased consumer/family member employment.

Enrollment
- Revise the language to clarify that the strategy is for counties to begin to move toward full service commitment to the clients and families.
- Counties will be requested to identify their priority focal populations and how many clients they can commit to serve in the initial plan.

Small County

- Consider changes to decrease administrative burden of plan and implementation for small counties, while maintaining critical elements for transformation.
- Include small county minimum in proposed distribution formula.

Outcomes and Performance Measures

- Scheduling stakeholder workgroups to begin May 4, 2005 to get input on performance measures.
- Add focus on impact of untreated mental illness on individuals and include individual measures in performance measurement.
- Establishing interim progress reports to ensure that counties implement their plans.

Short-Term Strategies

- Offered funding for collaborative training.
  - Client Network, NAMI-CA, UACC, and MHA.
- Continuing to evaluate potential implementation of Network of Care and Telemedicine.
- Working on statewide suicide prevention plan.

Overall Requirements

- Review plan requirements for opportunities to streamline while maintaining commitment to promoting transformation.
  - Allow summaries of planning process for those with fully approved planning funding requests.
  - Require completion of staffing assessment as part of Education and Training component rather than as CSS plan requirement.
- Continuing review of other strategies.

1. Stakeholder Questions and Comments

Involuntary Treatment

- I worked on MHSA from the beginning and throughout the process. I have attended many meetings and provided feedback. I am extremely distressed and exasperated about the inclusion of involuntary services. This is a huge slap in the face to clients.

- What are the current standards for involuntary care?
  - **DMH Response (CH):** A goal of MHSA is to reduce involuntary care. Involuntary treatment is an allowable expense only if the county can document that it is consistent with MHSA and meets all the requirements of AB 1421 checklists.

- What is the checklist for involuntary care? Is there a differentiation for adults, transition-age youth and children?
  - **DMH Response (CH):** AB 1421 states that involuntary care may only be funded if a county has provided all the services on the checklist. The point about differentiation by age group is important.

- The Client Network's position paper states that at its 2003 forum, clients voted MHSA as the highest priority. At the same time, clients were concerned that the implementation of the MHSA might not comply with the spirit and letter of the law. Use of MHSA funds for involuntary treatment is a direct violation of the Act.

- From California Network of Mental Health Clients' position paper, Page 7, #3: *The permitted use of involuntary treatment will destroy the trust that clients have cautiously developed related to the MHSA. Clients were promised that the MHSA would only be used for voluntary services. Based on this promise, they mobilized their efforts and joined the rest of the mental health community to promote Proposition 63. This promise would be broken, and the hard-earned trust destroyed.* No more broken promises. I feel like I've been punched in the stomach by the Department.

- The CSS DRAFT Plan Requirements should specify that involuntary treatment cannot be funded by MHSA. It is not only a betrayal of the intent of the Act, but also of the letter of the law.

- I am disappointed that DMH is not taking a stand that MHSA funds should not be used for involuntary services. There is still a lot of distrust, because people worry that more money will fund locked services.

- Clients, family members and advocates should use the input time between now and April 11 to let DMH know that forced treatment with MHSA funds is unacceptable. I feel betrayed by this direction. It is absolutely not the right thing to do to achieve transformation.

- Money needs to be in the MHSA for involuntary services because without it, consumers will lose part of the safety net. Some counties are already closing their hospitals so that consumers are being sent out-of-county.

- I support the DMH stance on involuntary services. Without it, there will be discrimination against clients in the criminal justice system. If voluntary services do not work, clients and family members need another alternative.

Cultural Competence

- The essence of cultural competence is to deliver services in a client's cultural context. Just to provide language access is not adequate.

- I see improvement. I see omissions. The DMH PowerPoint presentation provided only general themes so maybe the details exist, but were not presented. At the cultural competence meeting, stakeholders created an extensive list of different unserved groups. Provide such a list to the counties so that they would know they should consider all of these groups when making their plan.

- Encourage expansion from cultural competence to cultural proficiency, in order to be responsive to our clients and their needs. Proficiency speaks to the ability to be able to provide services in a cultural context. Think about how to define success for each person in the system.

- Under cultural competence, there was consideration for ethnicity and “lifestyle.” I assume gay, lesbian, bisexual and transgender people were included, but to use the term “lifestyle” is demeaning.

- No one talked about lifestyle at the cultural competence workgroup; they talked about gay, lesbian, bisexual and transgender people.

- Consider cultural competency within suicide prevention for transition-age youth.

- Include the culture of poverty and the culture of rural communities.

- Refugees need identification as a special group with special needs. These needs make it difficult for them to be served under the existing structure because they are a culturally and linguistically diverse population. Those living in the Bay Area come from 90 different countries alone. This requires multilingual clinicians as well as specialized treatment policies that address torture survivors, who are often too traumatized and fearful to seek treatment. Most of the federal funding for providers of psychological services for torture survivors has been cut. Counties are going to have to fill this shortfall and integrate the needs of torture survivors into the new mental health system.

- Cultural competence is not perfect but we are beginning to collect data and make changes.

- In terms of cultural competence, it is more important to take care of the people with severe mental illness who are already in the system but are still underserved than bring in more people.

- Most DMH staff do not understand the culture of recovery.

- Train department leaders to be more sensitive about cultural competence. Sometimes they do not understand the cultures in their communities and make inaccurate assumptions about how things work. Culturally competent staff would help eliminate ethnic disparities.

- It is good to see emphasis on reduction of ethnic disparities. Yet the needs of Californian immigrants are not being met. MHSA provides the opportunity to transform the system. Assure that when counties provide their plans, they show how they are going to measure changes in cultural competence.

- Implement a short-term strategy for a special allocation to tribes who will become involved with MHSA. DMH and counties are culturally incompetent. Listen carefully to those who have spoken about cultural competence.

- Cultural competence also stresses language that is crucial for the Asian and Pacific Islander populations. For example, at this morning's client and family member pre-meeting, at one table were nine people speaking four languages who were unable to speak to each other. About 15-20 consumers came to the client and family member pre-meeting this morning. But they did not understand what was going on. Our group felt that even if they did not speak English and therefore did not understand, it was still important to show Asian faces.

- The stakeholder process does not work on a cultural level for Asians, who do not tend to sit around and complain. These clients need self-advocacy training.

- Outreach, outreach, outreach especially to Asian-American communities. Then work on community engagement, including staffing.

- In order to serve a population that does not speak English and is outside system, fund outreach and engagement. The last policy for it was from the 1970s. Make this policy effective.

- In Los Angeles County alone, there are 200 different languages. What is the DMH's plan to reach out to them?

- Deaf culture is as much a culture as any culture in this country. It is an actual culture with its own language. It is wholly appropriate to include the deaf without looking at the overall disability community. Establish a part-time position in DMH for the deaf population.

Age Groups

<u>Children and Youth</u>

- Include a statewide standard for portability of services from one county to another, especially for foster children.

- What is "wraparound"?
  - **DMH Response (Mike Oprendek (MO)):** Wraparound is providing whatever it takes to help the child in children's services. If they need a backpack, respite care, a ride to practice, it will be provided.

- Wraparound is tied into the Department of Social Services in most counties. This is a concern for many families. Since one of the goals of MHSA is that clients not lose custody of children, DMH must work with Social Services to ease the burden of the family, providing respite care without fear of removal.

- MHSA speaks to a Children's System of Care, not necessarily through the CSOC program, which had some inefficiencies. Many children meet the criteria for services who do not meet CSOC program eligibility.

Transition-Age Youth (16 – 25)

- Ages 16-18 is an important time in a young person's life. Transition-age youth with SED do not learn the important life lessons at that critical time and yet the system "graduates" them. For youth to make the successful leap to adulthood, they need services specifically tailored for them.

- Include more about teen consumers: include youth as participants and as leaders, train them to be better mentors.

- Peer-run programs are especially important for transition-age youth.

- Transition-age youth whose parents are not in the home and transition-age youth who are gang-affiliated and have SED are particularly at risk. If they are gang-involved and/or dual-diagnosis they need specific targeted support.

Older Adults

- While wraparound is important for children, families and youth, it is also crucial for older adults.

- In the age-based workgroup, there was a discussion about transition-age adults. This group was omitted from the PowerPoint presentation.
  - **DMH Response (CH):** DMH did consider this group because the transition is important. However, the Department concluded that it would be very difficult for most counties to focus on five separate age groups.

- Most older adults services are focused on transition-age adults; not as many are focused on the very elderly**.**

Funding Guidelines for Age Groups

- There should be more guidelines for funding by age groups. Without them, older adults will be left out of the process in many counties.
  - **DMH Response (CH):** DMH is not leaning toward specific funding percentages for each population. This is a local issue. Counties must include all four age groups in their plan; leaving out one age group would not be acceptable.

- DMH omitted the concept of providing guidelines from DMH for division of money among different age groups from the financing workshop. Include such guidelines.
  - **DMH Response (CH):** DMH is leaning toward not doing that, because of the challenges for small counties. Some already feel that DMH is too directive. The Department is leaning toward local priorities.

Housing, Facilities and Other Support

- Overall comments need to include stable housing with appropriate support services. Safe apartments are important.

- Use some of MHSA for housing, with tax incentives for landlords to rent to mentally ill consumers.

- Housing is needed for domestic violence, transition-age youth, etc. Housing needs to include integrated care.

- Self-help groups will also need facilities, time and money. With the cost of real estate, counties will have trouble providing this.

- Creating an outcomes-based system will require state-of-the-art technology. Counties will have trouble absorbing this. If these issues are not addressed, then the system will fail.

- Create a universal transportation plan with vouchers or passes that are honored by any and all public transportation, including taxis. This is essential for seniors and the disabled.

- In California, SSI recipients are not allowed to get food stamps. Low-income people do not have access to quality, nutritious food or to an adequate quantity of any food. Some people are eating dog or cat food. Add a food stamp program within MHSA.

- Primary care services provide many enabling services, such as interpretation, to mental health clients as part of wraparound. Are these included in MHSA?
  - **DMH Response (CH):** One of the best aspects of MHSA is its flexibility. On the other hand, it creates a great challenge for counties to assess their priorities. There is no absolute prohibition.

- Primary care service providers are often the only providers in rural communities. It is good to hear there is flexibility.

Accountability and Transformation

- Where does the public feedback at the county level go? Will DMH review the county public feedback?

- The input being provided is in word engineering, not policy. In terms of measuring accountability, county Mental Health Boards and clients and family members should be arbiters about whether a client and family member-sensitive system has been implemented.

- All services need to meet Children's and Adult's Systems of Care requirements.

- Will enrollment be included during the performance measures discussion?
  - **DMH Response (CH):** Definitely. “Full service” means individual tracking to have comprehensive information on outcomes. Measures will be similar to AB 2034, but will be more comprehensive.

- There need to be more guidelines to address Quality Improvement.

- The ethics issue is not in the requirements. The mental health system has abused clients. A code of ethics is needed for clients.

- The transformation is there and people are talking about it. It is important to see we are moving forward, not getting off track.

- There will not be transformation if it is audit-driven, so that providers are spending too much time with documentation. For example, when serving a Vietnamese patient, the provider must take the time to translate notes back into English for audit purposes.

- The budget shows the heart and soul of what is being transformed. Make the budget transformative. There is a line item for flexible funding, such as childcare. There needs to be approaches for language capabilities. Wellness and empowerment is a new concept. Support deliverables and community organizing.

Client and Family Member Empowerment and Networking

- I see an absence of the idea of client empowerment, client networking and groups. These concepts seem to have been changed into education. Clients must be able to get together to talk to each other.

- It is important to provide opportunities for clients to express themselves through the arts or recreation, find a way to break the tension, have fun and raise their spirits. If counties add a little of that, it might provide a way to open people to change.

- Include more family education. There are not enough specifics about families and caregivers.

- Where is DMH in terms of family advocates?
  - **DMH Response (CH):** DMH is not specifically working on this, so much as on family support and advocacy.

- Add family advocates, not just family educators.

- Neither the CSS DRAFT Plan Requirements nor the stakeholder process in the counties is living up to our standards. I work at San Jose Community College on an empowerment project. The president of our college is organizing a task force on education-based recovery. This type of stakeholder should be included.

- Write materials in laymen's terms to increase understanding.

County Size and Geographic Isolation

- What qualifies as a "small county"?
  - **DMH Response (CH):** Generally a small county is one with a population of 200,000 or fewer. Thirty-four (34) counties meet that definition.

- Geographic isolation exists in a number of large counties. People can get lost in these rural pockets. Is there consideration for large counties with geographic isolation?
  - **DMH Response (CH):** The small county consideration is for those that do not have infrastructure. DMH may also look at the issue of geographic isolation.

- Instead of defining considerations for small counties, focus on geographical isolation.

- Make the funding allocation by population. Los Angeles is the county most likely to be affected. Provide guidance for the larger counties.

Timing Concerns

- What is the delay in releasing the $150,000 for the education and training collaboration between the California Network of Mental Health Clients, NAMI, and United Advocates for Children of California (UACC) and the Mental Health Association (MHA)?
  - **DMH Response (CH):** Before spending money DMH needs spending authority and contract approval, which takes time.

- Supplantation is a huge piece of CSS. When will the policy be released?
  - **DMH Response (CH):** The supplantation policy will be released as soon as it is complete. This will be no later than May 15 and might be earlier.

- Make a grant by May 15 from DMH to counties for at least ten times the planning grant. If no money flows into the counties until December or January, the whole effort will fall on its face.

- Community-based organizations are concerned about how fast the implementation process is moving. The writing and passage of MHSA was a consensus-driven process. This process is not. Look at programs that work now and fund them, rather than wait for the full planning process. Fill in the gaps for children. Reconsider the May 15 timeline for the final requirements. Not everyone's voices have been heard.

- The process is moving way too quickly. When you get input, you may be getting answers, but not moving toward consensus. This is the biggest change in the mental health system in memory. Do it right.

Northern vs. Southern California Meetings

- Where will workgroups be held in May?
  - **PHCG Response:** In Sacramento.

- Divide meetings between north, south and central California.
  - **DMH Response (CH):** At the first general stakeholder meeting in December, DMH asked stakeholders what they wanted. Based on feedback and staff resources, DMH decided to hold general stakeholder meetings in northern and southern California once every three months, workgroups on specific topics in Sacramento and statewide conference calls about each of the workgroup topics.

- Not everyone can travel to Sacramento. Can some of the planning money be used in a more equitable manner, for instance sponsoring some meetings throughout the state?
  - **DMH Response (CH):** DMH understands this perspective. The challenge for DMH is having enough staff to hold the workgroup meetings in more than one location. Based on feedback, Sacramento was the chosen site for the workgroups.

- Southern California consumers are seriously affected by the Sacramento-only meetings. There should be meetings in Southern and Central California as well as Sacramento.

Outreach

- People in board and care homes are intimidated. I stand for the silent majority in board and care homes that are fearful of their operators. The stakeholder process needs to include getting their feedback. They need support.

- Counties need to reach out to stakeholders residing in institutions, both in and out of the county.

- Counties should conduct focus groups in IMDs, locked facilities and board and care homes.

Human Resources

- Front-line workers are dedicated along with clients and family members to transforming the system. DMH should ensure that front-line workers are involved in the planning process from beginning to end.

- There is a critical shortage of providers. When cultural competence is added, e.g. ethnicity, language and gender, the shortage becomes even more critical. Without qualified staff, MHSA will overburden the current providers.

- How can we build programs without the workforce to support them?

- When will the trainings start? The California Social Work Training Centers would like to be able to include training in the next school term. Is it possible to make training and education a priority for early implementation, so the new social workers can be trained?
    - **DMH Response (CH):** The first workgroup on Human Resources is June 16, at which time this will be discussed.

Document-Specific Changes

- Provide a clear definition of "full service."

- There needs to be more definition in Section V, System Capacity Section about the logic model for selecting program options, including programs that divert from involuntary services. Find ways to help people not need such intensive services.

Communication with Counties and State

- I want to express appreciation to DMH, especially to Carol Hood and Steve Mayberg. Mental health advocacy has come a long way. The CSS DRAFT Plan Requirements is a living document that will be streamlined. I believe we are listening to each other. Let us collaborate and stand together. We are trying to work together.

- How do we maintain the momentum of Proposition 63? It seems like the election was only the first step in a battle. Elect people to office who believe government should be involved in social programs.

2. Small Group Responses to DMH Presentation

At the Sacramento general stakeholders meeting, stakeholders were asked to identify in small groups any major issues missing in the DMH presentation. Each table suggested a missing issue as well as a recommendation for major change to the CSS DRAFT Plan Requirements. Following is a summary of those comments from the small groups.

Involuntary Services

- Involuntary treatment should not be allowed under the MHSA as it is a violation of the spirit and intention to use MHSA for involuntary treatment.
- Many people left the general stakeholder meeting because they were so upset about the decision about involuntary treatment.
- You cannot reform a system that does not want to be reformed. We need to be loud and clear and we may need to take more radical actions about involuntary treatment. Little has been accomplished.
- Transformation is real client-respectful programs of choice, not involuntary treatment.
- What does DMH mean when they say counties must be consistent with MHSA funds in terms of providing involuntary services with MHSA funds?
- Only fund voluntary treatment with MHSA funds. Use other funds for involuntary treatment.

- There is no coercion in transformation. Fund only voluntary services.
- Differentiate between adults and those under 18 and not emancipated in regard to involuntary treatment and having to meet all the checklist qualifications in order to receive involuntary treatment provided through MHSA funding.
- No money should be used for involuntary services, but provide services to those in locked systems to help them access recovery. Let people in locked facilities know transformation is possible. That way fewer people will need locked services and can learn they can move forward with their lives.
- Ask those in locked facilities what they need or to give some input.
- You cannot deny services that people need, including involuntary services.

Cultural Competence

- DMH should list the many types of unserved and underserved populations and require counties to consider them when deciding to whom to outreach and serve. Require counties to track those groups to see if their access increases.
- Expand services to all clients, including refugees.
- Native American tribes must be given special funds to address their own mental health needs assessments, planning and implementation, and to be able to evaluate the outcomes of their own plans.
- Native American consumers and family members and community members must be given the opportunity to get educational scholarships, paid training and meaningful employment as providers of mental health services and supports.
- Funding for Native American tribal services and supports must be directed toward the most at-risk and unserved members of each tribe. The county mental health departments should not be involved in or oversee the planning for the distribution of MHSA funds to Native American tribes.
- In general, tribes can act as their own pass-through agents for MHSA funds.
- Enrollment programs cannot be obfuscated into culturally competent services by word engineering.

Age Groups

- Small counties should be able to start with one age group and add others, as they are able.
- There is a tendency to talk about adults and then add on children. Children's services need to be included as their own system.
- Emphasize children's services in the planning process to ensure sufficient resources for unmet needs.
- Provide respite care for older children who are not in foster care and who have mental health issues.
- Assure that foster care children placed out-of-county receive services they need where they live. Funding should follow the child. DSS knows where all the children are placed and allocations should be made to follow the child.
- Transition-age youth need targeted peer counseling and other services. Add more detail about transition-age youth and seamless services.
- Address the needs of youth in dual diagnosis groups.

- Nothing in any of the language of the presentation addresses older adults despite all the comments in the group discussion. DMH should reaffirm its commitment to older adults, requirements for transition-age adults, ages 50-60. This is an underserved and underfunded group.
- Older adults have special needs.
- Reaffirm DMH's commitment to an Older Adult System of Care, both in principles and outcome. Emphasize MHSA requirements for older adult services, including transition-age adults.
- Changing the name of "enrollee" based services does not change the concept.

Accountability and Transformation

- Consumers need to be involved in accountability.
- Outcomes and accountability should not be tied only to numbers served.
- There is no specific reference to quality of care. Acknowledge explicitly that these services will be high quality.
- Simplify the requirements without diminishing transformation.
- Counties are coming together in awareness of needs to help clients and families.
- Support transformation within long-term facilities.
- Need one goal to transform the mental health system in each county by a set date. No pushing back, no delays.
- The prescriptiveness of the CSS DRAFT Plan Requirements takes focus away from transformation. Therefore it would be helpful if counties were asked to describe their vision of transformation in terms of what their county's system would look like in ten years.

Wraparound, Housing, Facilities and Other Supports

- Make sure affordable permanent housing is included.
- Outreach to homeless consumers. They need housing. Serve those who want treatment.
- Explicitly require that county CSS plans describe strategies to provide alternative community integrated services for clients now placed in IMDs, group homes, other institutional settings, and board and care homes.
- Transportation for services is written into the Act.
- Families need an increased level and variety of services available through the mental health system and better cross-systems collaboration. Families need wraparound available to them earlier. MHSA could extend the kinds of services that are needed as supports to medically necessary services.
- Reduce homelessness and jail time.

Client Empowerment

- Clearly state that all clients have full, complete and ready access to state-of-the-art treatments, including medications, regardless of insurance coverage.
- Assure services will be developed that are recommended by consumers and family members and that the costs of enrollment programs do not preclude client and family member programs.

- Assure real client outreach, inclusion, direction and oversight. Eliminate tokenism. Level the playing field.
- "Consumer" has suddenly become a nasty word**.** More and more stigma is coming out of this Act than there is activity to prevent stigma. If something is not changed or this issue is not addressed, it will be impossible to work with staff.
- Include program elements that raise the spirit of people whose spirit may have been crushed by their illness or outside forces, such as rape. Help people experience joy.
- The line between consumers and consumer staff can prevent some from being included on county steering committees.
- Provide childcare so that clients and family members can attend meetings.
- Post Traumatic Stress Disorder is ignored, clients are misdiagnosed, then mis-medicated, causing re-traumatization and further mental illness due to toxic mis-medication.

Process, Timing and Funding

- $150,000 for training for outreach is a paltry sum and inadequate to reach out to the groups.
- Get funds out to communities as soon as possible: provide ten times the planning allocation to start programs.
- Keep IT and training together and get the money out.
- The funding allocation should place its emphasis on general population more than the other items on list. People in poverty are not the only ones with mental illness.
- Will the financing options reward counties that have their act together or those that do not?
- There continue to be major concerns and questions about the financing options or set-asides that need to be integrated, along with outcomes and accountability, into the CSS Plan Requirements.
- Stop considering services within the context of the funding stream and start considering the individual's need for service.
- Receiving feedback in this fashion was good, but finalizing the CSS Plan Requirements in this way is dangerous and unacceptable. A consensus process to finalize the guidelines is absolutely necessary and should be modeled after the effective strategy used in 1991/92 to implement Realignment. This will create a consensus document that would be accepted by a broad scope of partners and stakeholders.
- Do not allow MHSA funds to be used to bail out county budget problems**.** Do not allow simple re-funding of programs that had been eliminated due to decrease of realignment funding.
- Too much State control.

Dual Diagnosis

- Need to better address services to dual diagnosis clients, including clients who are chemically dependent, have a physical illness or disability or are developmentally disabled.

- Make accommodations for people with physical disabilities and other co-occurring illnesses and barriers.

Unserved and Underserved

- Those who do not have Medi-Cal and whose insurance does not cover the full scope of services should be eligible for MHSA funds.
- MHSA funding should be used to force mental health parity with private insurance.
- Assure access to treatment, including medications.
- Expand innovative socializing and crisis programs already in the system for the underserved as well as the new clients who are currently unserved.

Supplantation

- Clarification on supplantation so the counties can do their planning.
- Address issues of reinstituting services and supplanting.

D. Key Points from Client and Family Member Pre-Meeting Discussions

After the presentations by the counties about their stakeholder processes, there were presentations of the summary of positive themes and improvements needed in the county stakeholder processes, as discussed in the client and family member pre-meeting.

Summary of What Counties are Doing to Involve Clients and Family Members in Planning Process

- Clients and family members are being trained and hired in outreach to run focus groups.
- Clients and family members included in steering committees and planning process.
- Clients and family members focus groups in multiple languages and locations.
- Law enforcement is included.
- Large counties are using video conferences.
- Some counties have full-time staff working on the planning process.
- Client centers are places where all mental health issues can be discussed.
- Mental health administrators welcome client and family member involvement and regular meetings.
- Focus groups are client-run at client facilities.
- Responsive director and Mental Health Board.
- 50% participation of clients and family members on all committees. Planning committees have client and family member co-chairs.
- Training on how to participate fully in MHSA planning is conducted by client and family member organizations.
- Multiple opportunities for input are provided.
- Readiness and leadership training.
- Rural outreach and discussion groups.

- Use of existing collaboratives.
- Clients and family members are hired to work on plans.
- Media coverage and publicity.

Summary of Improvements Needed in County Stakeholder Processes

- More training and education for consumers and family members in participating in planning process and with Mental Health Boards.
- County leadership must believe in what they are doing. There is need for greater understanding of what is truly needed, how to inform clients and family members.
- More understanding of the needs of special needs children, and low-functioning clients.
- Process moves too fast to involve clients and family members effectively.
- More work with schools.
- Move to recovery model and away from medical model.
- Create feedback loop so clients and family members stay informed about how input is being used.
- Provide clearer information on how to be involved, including better publicity.
- All meetings must be open.
- Create special funds to make cash available for up-front reimbursement for client and family member involvement.
- Use consumer-friendly, accessible locations for meetings.
- Keep consumer voice in forefront of input gathering so special interest groups do not outweigh it.
- Avoid closed-door decision-making.
- Conduct outreach and involve unserved and unrepresented, including refugees, tribal groups, and transition-age youth.
- Conduct training on engagement and outreach (for staff and volunteers).
- Conduct training for staff and administration on sharing balance of power and system transformation.
- Set aside money at county level for education and training.
- Spend less money on professional consultants and more on client and family member training and involvement.

E. County Planning Efforts

Representatives from six counties highlighted the consumer involvement in their MHSA planning efforts. These presentations provided contact information and useful resources for enhancing any county's planning process.

1. John Campbell, Los Angeles County

The Los Angeles County MHSA planning process started a year ago and continues to outreach to all stakeholders. The county has funding for involving stakeholders in community-based planning, including money for transportation and childcare. The critical planning period is between now and June. The county expects to complete its

draft plan by July, with a thirty-day review period, followed by public meetings in July or August. The plan will be submitted to DMH by September. This has been a vibrant, dynamic, and very fast process.

There are five centralized planning groups: children, transition-age youth, adults, older adults, and cultural competence. Stakeholders can contact Los Angeles Department of Mental Health to find out when meetings are scheduled, what to expect, and how to get there.

For More Information

- Website: http://dmh.co.la.ca.us/. Link on right side for stakeholders' process.
- Public telephone number: 213-738-2369.
- Email: jproctor@dmh.co.la.ca.us.

2. Dorothy Hendrickson, Orange County

Orange County's community meetings started in January with an MHSA kick-off celebration. There have been six meetings and over 24 stakeholder groups. Two of the six meetings were conducted in Spanish and Vietnamese in those communities, attended by about 260 people per meeting. At each, planning applications in appropriate languages were available, along with staff to teach people how to complete the applications. Of all applicants, 80% have been clients and family members and 270 have been other stakeholders. The county submitted its Plan-to-Plan request on March 11, which is posted on the county website. Since counties are not in competition for each other's funding, the planning process encourages sharing resources.

The county held a cultural competency convening, with a handout of Frequently Asked Questions (FAQ) in English, Spanish and Vietnamese. These are available for people to take to other meetings. The county also reached out to its mental health line staff, for whom a survey was developed. Out of 805 staff, 426 returned responses. The survey showed that staff was aware of MHSA and its goals. The survey also highlighted the county's appreciation of staff and how their opinions will be used.

The county is in the process of developing its training manual, laying down a foundation for its planning process. Before the process begins, four-hour training sessions will be conducted throughout the county, at different times and in different places convenient to clients and family members. The county plans to film the second training workshop and dub the film in Vietnamese and Spanish. The Department is trying to provide the information in a culturally competent way. The recovery model will be discussed in the training manual, which will also include a two- to three-page executive summary for each component, as well as source documents used for the writing of Proposition 63.

The first steering committee meeting will be held after all training is completed. The steering committee has 56 members. Focus groups will be conducted using already existing groups, including faith-based, drop-in centers, etc. There is one full-time staff and two more are scheduled to be hired. The county also expects to hire part-time client and family member mental health workers, to help bring the community to the focus

groups. It is important to remember that county government has to move slowly, with many rules and regulations to adhere to.

For More Information
- Website: www.ochealthinfo.com/prop63.
- Telephone: 714-834-6023.

3. Bill Brennenman, Riverside County

Riverside County is focused on community input, reaching out to as many people as possible: clients and family members, staff, community agencies, anyone interested in providing feedback. The county spent considerable time and thought determining the right questions to ask about cultural competence, housing, access, and services. Surveys have been developed that can be mailed or emailed and are posted on the county website. Next, the county is working on the infrastructure to process the wealth of information: how to consolidate it and interpret it.

Before initiating focus groups, the county provided two days of training to over 40 facilitators so that the groups are consistent and standardized, and the information can be more easily used. The Department has relied on a local community-based organization to recruit people for focus groups and training them. Focus groups are held with clients, family, staff, agency focus groups and regional public forums. The Department will train stakeholders about committee memberships.

The county reached out to clients and family members by calling upon all staff, agency, family advocates and liaisons. As a result, the Department was able to recruit about 50 clients and family members to be part of process. At this point, the county has five committees: children and youth, adults, older adults, housing, and criminal justice. Other subgroups have grown out of these first five.

The county hopes to have the plan ready by the end of summer. It is committed to the process of full engagement.

For More Information
- Website: www.co.riverside.ca.us
- Telephone: 951-358-4522
- Email: mhsa@co.riverside.ca.us

4. Dave Schroeder, Sacramento County

Before the MHSA planning process started, Sacramento County had a very active client and family member network and an active Mental Health Board. Its process emphasizes partnership. The county has a peer plan and task forces by age-based group and cultural competence. Each committee is composed of 50% clients and family members. The Department has said that clients and family members are the decision-makers. The county mental health director is excellent and very supportive of the process.

Planning money is targeted to the involvement of clients and family members, while the Department provides its services in-kind. The county pays for transportation, provides childcare, and caregiver care. There are patient and family advocates who work only on the planning process. The Department has scheduled an initial seven countywide trainings in places and times convenient to clients and family members. It is training people to go into the IMDs and board and care homes. To identify clients and family members, the county is drawing on self-help centers, the Client Network, CSOC and NAMI. Youth are involved through the efforts of youth advocates.

The county is working to obtain client and family member input. An adult and youth advocate and a family advocate sit on the management team of the county, so clients and family members have access to and a role in all the decisions. Clients and family members are reached by U.S. mail and by email. To reach youth, clients and family members go to video arcades and malls. Clients and family members drive the transformation. The county has also produced a television show, with live call-in about MHSA, children, adults, older adults and cultural competence. They plan to do two shows per month, on education, alcohol and other drugs, social services, and criminal justice.

For More Information

- Website: www.mhsasac.org.

5. Dan Souza, Stanislaus County

The MHSA planning process in Stanislaus County relies on a multi-level stakeholder process. Anyone who wants to listen and provide feedback is invited. The county began this stakeholder process before it received MHSA planning money, believing it is an investment in the future of leadership. The steering committee is co-chaired by the Mental Health Board and Department staff. Consumer advocates are included. The steering committee guides the overall process. After holding information meetings and town hall meetings, the Department concluded this was not the best way to obtain input. Now it will conduct targeted focus groups and is training people to be facilitators. Facilitators will go to any reasonably sized group. They will conduct many of these groups and expect to obtain rich input.

The Department will hold all-day system of care workgroups, open to everyone. It will develop themes with strategy recommendations. These recommendations will go to committees to make recommendations.

The Department recognized early that the success of the process depends on a viable consumer organization. The county wants consumer-run services. Consumer staff members started the process to develop a local chapter of the Client Network. The county arranged for in-kind staff, reimbursement for client and family member expenses and provided office, computer equipment and consultation. The Client Network chapter developed an excellent board of directors and wrote a successful grant application to a local foundation, winning $25,000 over several years. The county is using planning money to hire a consumer advocate who will provide staff support to the Client Network.

Stanislaus also has a strong NAMI chapter, with strong advocates. The county does not have United Advocates for Children of California (UACC) and is using its parent partner group as advocates for parents and caregivers of children.

The county is in the process of solidifying the plan for consumer outreach, especially the ones usually not reached. This includes outreach to board and care homes as part of the stakeholder groups. The county will provide support and transportation for groups and will provide stipends to more formal stakeholder groups.

The county recognizes that there is a generation that gets most of its information on the Internet. It also uses the newspaper, and an on-line survey form. They will feed the responses into a database that will use key words to pull out themes. Despite all this, the county knows that there is not enough money to do everything needed to build a fully transformed system.

For More Information

- Website: www.stanislausMHSA.com.
- Telephone: 209-525-7423

6. Charlotte Lappe, Colusa County

Colusa County is small, which can be good: the county has a good communication system. Two years ago the county was funded by the Sierra Health Foundation to form a Learning Circle to network and share information about resources. In January and February, the Department met with the Learning Circle, described the MHSA and formed a partnership. Together, they developed a survey of five key questions on outcomes, barriers and future services. They received excellent feedback**.** The Department made spreadsheets and presentations and translated them into Spanish. They regularly report back to the Learning Circle.

To reach the large unserved and underserved Latino population, the Department found a local, respected organization that could give a personal invitation. About 50 people came to the first meeting, of whom 23 were monolingual Spanish speakers. The county provided interpreters. The Mental Health Department received a First 5 grant to discuss brain development; first it provided training and then participants provided the Department with feedback. People were very engaged. As more people provided input, the presentations have expanded. The county held a consumer meeting with 34 people, including a number of Spanish speakers. Using familiar faces, going to their locations and partnering with a respected organization has helped the outreach effort. The Department also works with schools, which are often the hub of their communities in small counties. Using their recommendations, the Department has been able to successfully reach out to these small communities.

For More Information

- Telephone: (530) 458-0520